DIVISION OF MEDICAL ASSISTANCE

INSTRUCTIONS FOR THE 2006 MENTAL HEALTH RESIDENTIAL TREATMENT COST REPORT

For Agencies Providing
Mental Health Residential Treatment Services

Reporting Deadline: January 31, 2006

Instructions For Completing the Mental Health Residential Treatment Cost Report

TABLE OF CONTENTS

CONTACT INFORMATION:

If you have any questions regarding the Mental Health Residential Treatment Cost Report, please feel free to contact Deidra Oates, DMA Rate Setting Section at (919) 855-4200. Fax (919) 715-2209. Email Deidra.Oates@ncmail.net

To Submit by Mail or Delivery

Mail address:
NC Department of Health and Human Services
Division of Medical Assistance
Attn: Deidra Oates
2501 Mail Service Center
Raleigh, North Carolina 27699-2501

Delivery Street Address:
NC Department of Health and Human Services
Division of Medical Assistance
Attn: Deidra Oates
1985 Umstead Drive
Raleigh, North Carolina 27603

Instructions For Completing the Mental Health Residential Treatment Cost Report

I. GENERAL INFORMATION

Objective:

To obtain cost information from providers to assure that the rate setting process is comprehensive and that the Mental Health Residential Treatment rates are reasonable.

Enabling document:

Each facility's Medicaid Participation Agreement

Report Due Date:

All facilities must complete the cost report for their operations from their most recently completed fiscal year financial statements prior to the due date of the report, which is **January 31, 2006.**

Who must comply? All agencies that receive Medicaid payments for Mental Health Residential Treatment services, with the exception of those who are exempt. Please see the Exemption form on page 30.

Action for Noncompliance:

If cost reports are not submitted by the January 31, 2006 due date, the Division has the authority to assess a 20% penalty against future payments until the agency submits the required cost report.

Is the Information Provided on the Cost Report Subject to Verification? Yes

File Electronically:

We strongly recommend that you submit your information electronically. All information and forms for the 2006 Mental Health Residential Treatment Cost Report are available on the Division of Medical Assistance web site at:
http://www.dhhs.state.nc.us/dma/mentalhealth/mentalhealth.htm.

Retain a complete paper copy of your cost report for your records. In addition to electronically sending the 2006 Mental Health Residential Treatment Cost Report, please sign the **Certification of Accuracy** at the bottom of Schedule A and **mail the Schedule A with the original signature** to the mailing address noted below. Your cost report submission will be considered incomplete until this form is received at DMA.

If You Have to Mail the Cost Report/Diskette:

If necessary, you may submit paper cost reports. However, they must be legible.

Do **not** mail the instructions for completion of the cost report.

Mail address:
NC Department of Health and Human Services
Division of Medical Assistance
Attn: Deidra Oates
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Telephone: (919) 855-4200

Delivery Street Address:
NC Department of Health and Human Services
Division of Medical Assistance
Attn: Deidra Oates
1985 Umstead Drive
Raleigh, North Carolina 27603

Instructions For Completing the Mental Health Residential Treatment Cost Report

COST REPORT

GENERAL INSTRUCTIONS

The 2006 Mental Health Residential Treatment Cost Report captures the costs and days associated with providing the specific *levels of care.* A detailed set of instructions is provided for guidance on which expenditures should be placed on each line of the cost report. Agencies will also need to ensure that a copy of their audited financial statements, if available, or their un-audited financial statements are submitted as supporting documentation. Cost Reports will be considered incomplete without the financial statements.

The Mental Health Residential Treatment cost report should represent costs of providing these services that are within the Medicaid service definitions and those that are not. Those costs **outside the Medicaid service definitions should not be reported in the Medicaid *allowed numbers.***

All information and forms for the 2006 Mental Health Residential Treatment Cost Report are available on the Division of Medical Assistance web site at:

http://www.dhhs.state.nc.us/dma/mentalhealth/mentalhealth.htm.

The **2006 Mental Health Residential Treatment Cost Report** is comprised of the following individual schedules:

SCHEDULE "A"– Signature Certification of demographic information (original required)
SCHEDULE "A-1"– Multiple Facilities Form
SCHEDULE "B" – Revenue Schedule
SCHEDULE "C" – Expense Schedule
SCHEDULE "C-1" – Medicaid HRI-R Expenses
SCHEDULE "D" – Related Party Transactions

Each schedule must be completed and the original Schedule A **signature page** must be submitted in order for original signatures to be retained in the DHHS DMA Rate Setting office.

Reports are due January 31, 2006.

Instructions For Completing the Mental Health Residential Treatment Cost Report

INSTRUCTIONS FOR SCHEDULE A

Part I General

Indicate by checking the appropriate box, whether you are completing this report on a **cash** or **accrual** reporting basis. The cells that are highlighted in green indicate where you are to enter the data. This data is carried from schedule to schedule and will not be carried forward if not entered where indicated.

1. Enter Tax ID # and the name of the agency or facility as licensed by the NC Division of Social Services or NC Division of Facility Services; physical address of facility, city, state and zip code of facility.

2. Enter mailing address if different from physical address of facility, city, state and zip code.

3. Enter the name of the Contact Person/Director/Administrator. This is the person responsible for the Cost Report and able to answer any questions that may arise.

4. Enter telephone number (including area code).

5. Enter e-mail address.

6. Enter fax number.

7. Enter the Medicaid Provider #. **You must** enter your Medicaid Provider number as assigned by the NC Division of Medical Assistance. If this number changed during the reporting period, please provide the prior Medicaid provider number as well in box #10.

8. Enter the Fiscal Year End Date for which you are reporting costs. This should be the most recently completed/audited fiscal year.

9. Enter the number of months the facility was in operation during the cost reporting period.
   Example: If the facility was in operation for a full year, enter # 12 months, From October 1, 2003 through September 30, 2004 or July 1, 2002 through June 30, 2003.

10. **You must** enter your Medicaid Provider number as assigned by the NC Division of Medical Assistance in box # 7. **If the license number changed during the reporting period, please provide the prior Medicaid provider number as well in this box.**

11. Enter the Licensed Bed Capacity for each Level of Care. Enter current licensed bed capacity of the facility as of the last day of the reporting period. (This is the same period as the audit period.) (This is the bed capacity licensed by the Division of Social Services or the Division of Facility Services.)

12. Enter total number of multiple facilities. Agencies with multiple facilities must fill out and attach a **Schedule A-1** and include each additional facility.

Part II Tax Information

13. Enter the tax status of the facility by checking in the space provided.

13a-b. Select either 13a - Voluntary Non-Profit or 13b - Proprietary by indicating the appropriate category.

Part III Resident Days

14. Enter the Total number of Non-Medicaid Resident Census Days. This is your census data for non-treatment days or is computed based on dates residents were admitted, discharged or on leave from the facility. Enter the total number of resident days for the facility during the cost report period. This number includes days residents were in the facility plus reserve bed days and therapeutic leave days. The number of days (Line 14) may be equal to or less than the number of Available Bed Days (Line 15a), but may **not** be greater.

15. Enter the Total number of **LICENSED** bed days available for **Non-Treatment** Resident Care. This is the total number of bed days for which the facility is licensed during the cost report period. The licensed bed days are computed by multiplying the number of licensed beds throughout the cost report period by the number of days in the period. If there is an increase or decrease in the number of licensed beds during the period, the number of licensed beds for each month of the cost report period should be multiplied by the number of days of the month. Please see the example on the next page.

Example: Cost report period is October 1, 2003 through September 30, 2004. The facility is licensed for 10 beds on October 1, 2003 and 12 beds on January 1, 2004.

Month/Year	Licensed Bed Capacity	Licensed Bed Days
October, 2003	10	310 (10 beds X 31 days)
November, 2003	10	300 (10 beds X 30 days)
December, 2003	10	310 (10 beds X 31 days)
January, 2004	12	372 (12 beds X 31 days)
February, 2004	12	336 (12 beds X 28 days)
March, 2004	12	372 (12 beds X 31 days)
April, 2004	12	360 (12 beds X 30 days)
May, 2004	12	372 (12 beds X 31 days)
June, 2004	12	360 (12 beds X 30 days)
July, 2004	12	372 (12 beds X 31 days)
August, 2004	12	372 (12 beds X 31 days)
September, 2004	12	360 (12 beds X 30 days)
Total Licensed Bed Days		**4,196**

15a. Enter the Total **AVAILABLE** Bed Days for **Non-Treatment** Resident Care. Available bed days are computed by multiplying the number of beds available during a month by the number of days in the month. Available beds may be different from licensed beds due to factors such as temporary displacement due to construction; a double bed room is required for a single recipient, etc. If there is an increase or decrease in the number of beds available during the period, the number of beds available for each month of the cost report period should be multiplied by the number of days during the month.

16. Enter the Total number of **Treatment** days for each **Level of Care**. This is your census data for treatment days. Enter the total number of Medicaid Resident Days reported for the facility during the cost report period. Medicaid Resident Days **do not** include reserve bed days and therapeutic leave days. The total number of Medicaid Resident Days for each level of care reported on Line 16 may be equal or less than the corresponding **Licensed** Bed days available by level of care on Line 17, but may **not** be greater.

17. List Total **LICENSED** bed days available for **Treatment**. This is the total number of licensed bed days during the cost report period. Licensed bed days are computed by multiplying the number of licensed beds throughout the cost report period by the number of days in the period. If there is an increase or decrease in the number of licensed beds during the period, the number of licensed beds for each month of the cost report period should be multiplied by the number of days during the month (see example for line 15).

17a. List Total **AVAILABLE** bed days for **Treatment**. Available bed days are computed by multiplying the number of beds available during a month by the number of days in the month. Available beds may be different from licensed beds due to factors such as temporary displacement due to construction; a double bed room is required for a single recipient, etc. If there is an increase or decrease in the number of beds available during the period, the number of beds available for each month of the cost report period should be multiplied by the number of days during the month.

Example: The cost report period is October, 2003 through September, 2004. The facility is licensed for 10 beds on October 1, 2003 and 12 beds on January 1, 2004 and had 9 available beds on October 1, 2003 and 10 on January 1, 2004.

Month/Year	Licensed Beds	Beds Available	Licensed Bed Days Available for Occupancy
October, 2003	10	9	279 (9 beds X 31 days)
November, 2003	10	9	270 (9 beds X 30 days)
December, 2003	10	9	279 (9 beds X 31 days)
January, 2004	12	10	310 (10 beds X 31 days)
February, 2004	12	10	280 (10 beds X 28 days)
March, 2004	12	10	310 (10 beds X 31 days)
April, 2004	12	10	300 (10 beds X 30 days)
May, 2004	12	10	310 (10 beds X 31 days)
June, 2004	12	10	300 (10 beds X 30 days)
July, 2004	12	10	310 (10 beds X 31 days)
August, 2004	12	10	310 (10 beds X 31 days)
September, 2004	12	10	300 (10 beds X 30 days)
Total Available Bed Days			**3,558**

The number of Available Bed Days (Line 17a) may be equal or less than the number of Licensed Beds Available (Line 17), but may **not** be greater.

Part IV Certification of Accuracy –

If the numbers submitted on the *Mental Health Residential Treatment Cost Report* ***for each level of care*** can not be verified on the Financial Statements, a supplemental schedule is required to support the Schedule C and C-1 entries. Providers whose Financial Statements do not have separate cost centers detailing mental health treatment expenses and the staff salaries/benefits prorated to coincide time spent providing these services, must separate and report, by service, all Mental Health Treatment Expenses. The agency's Executive Director must attest to the breakdown of expenditures from the financial statements to the *Mental Health Residential Treatment Cost Report.* If providing an Audited Financial Statement please have your Auditor attest in the space provided on Schedule A.

Instructions For Completing the Mental Health Residential Treatment Cost Report

INSTRUCTIONS FOR SCHEDULE A-1

If you are an Agency with multiple facilities, fill out and attach Schedule A-1 to include each additional facility.

Please note that the number of Resident or Occupied Days cannot exceed the number of licensed beds times 365 days.

If submitting a paper copy of the form, write on the appropriate line:

- the Tax ID number assigned to your Facility or Agency as entered on Schedule A
- the Facility or Agency Name as entered on Schedule A
- the Fiscal Year being used to report data as entered on Schedule A

INSTRUCTIONS FOR SCHEDULE B

This is the Revenue schedule.
Payments received from insurance, residents, family members, etc. for reimbursement of purchases of medicines and other purchases for residents should be netted out against the expense account and not reported as income under "other receipts".

If submitting a paper copy of the form, write on the appropriate line:

- the Tax ID number assigned to your Facility or Agency as entered on Schedule A
- the Facility or Agency Name as entered on Schedule A
- the Fiscal Year being used to report data as entered on Schedule A

When submitting an *Excel* version of the cost report, the header information is linked from Schedule A and does not need to be entered into any other schedules. The total lines will be automatically entered in the form. You need only enter data into the white boxes on the form. Gray boxes indicate that no value is expected and that the Medicaid Program will not cover these expenses. **The final total dollars allowed for rate setting will not include values from gray boxes.**

REVENUE

1. Enter revenue collected for or on behalf of residents from NC Medicaid.
   a) HRI-R
   b) CAP-MR
   c) OTHER Medicaid

2. This cell will total all of the revenue collected for or on behalf of residents from Medicaid (the sum of lines 1a through 1c).

3. List and enter revenue collected from Federal (Non-Medicaid) Sources.

4. This cell will total all of the revenue collected from Other Federal Sources (the sum of lines 3a through 3e).

5. List and enter all revenue collected from State Sources.

6. This cell will total all of the revenue collected from State Sources (the sum of Lines 5a through 5f).

7. Enter the <u>total</u> revenue collected from County Funds.

8. Enter the <u>total</u> revenue from Investment Income.

9. Enter the <u>total</u> revenue collected from Private Contributions.

10. Enter the total revenue collected from all other sources.

11. Total Revenue. (Add lines 2, 4, 6, 7, 8, 9, and 10).

12. Enter the total dollar expense from the Financial Statements. This value should balance to Schedule C line 106, TOTAL Column. **If submitting an *Excel* version of the cost report, this value will automatically update into Schedule C, line 106 of the TOTAL column.**

13. Subtract Line 12 from Line 11. This represents the facility's net gain (loss) for the cost reporting period.

INSTRUCTIONS FOR EXPENSE SCHEDULE C

Enter data directly into the cells/boxes that are white. The *Excel* program will do the math, total columns and carry balances forward in Schedule C and Schedule C-1 (light yellow cells/boxes) as well as carry values into the light yellow cells/boxes of other schedules. **Gray cells/boxes indicate that there is no entry expected and any values entered into gray cells will not be included in the totals used for rate setting.** However, you may use these cells, if necessary, to include all expenses to match to your Financial Statements. Use of the paper forms requires the user to total all columns and carry balances forward from schedule to schedule.

Position Count/FTE's per category: On the first line, **below the column headings**, indicate the number of full time equivalent personnel which are associated with and represent the costs for each program (except the administration columns 13 & 14).

> *Full-time equivalent (FTE) is defined as:* If a person works full time for one year with an agency, they are consider 1 FTE. If they only worked half time for a full year, they would be 0.5 FTE. FTEs can be calculated based on the number of hours worked divided by 2080 hours (which is a full time person for a full year)

No administration should be allocated to Medicaid (column 13) for items Medicaid does not cover. These line items have shaded boxes on them. Line 101 may be used for items not covered by Medicaid in order to tie expense totals to your Financial Statements.

If submitting a paper version of the Cost report, the SCHEDULE C-1 is required. Please complete and carry the summarized totals directly into the Schedule C. **When using *Excel,* enter the treatment costs into Schedule C-1 and it will automatically carry into the Schedule C.**

Providers of mental health treatment services, whose financial statements do not have separate cost centers detailing mental health treatment expenses and the staff salaries/benefits prorated to coincide time spent providing these services, must separate and report, by service, showing the mental health treatment expenses. The agency's Executive Director must attest (on Schedule A*)* to the breakdown of expenditures from the Financial Statements to the *Mental Health Residential Treatment Cost Report.*

Do not include Room & Board costs in Columns 1 through 4 of Schedules C or C-1. Room & Board costs corresponding to columns 1 through 4 are to be entered into the corresponding columns 7 through 10 on Schedule C.

TREATMENT COSTS can be covered by Medicaid as long as there is medical necessity and there is a treatment plan for the child. Please reference the provider service definitions for Residential Level I, II, III, IV, and PRTF for the specifics of the treatment costs to be included in the respective columns.

Instructions For Completing the Mental Health Residential Treatment Cost Report

MEDICAID TREATMENT EXPENSES

Cost Report Line Number	Description
1.	**Salaries/Wages - All treatment personnel's salaries and wages.** **a.** -Direct Care **b.** -QMHP **c.** -Other Staff
2.	**Employee Benefit Program** -Dental Insurance -Health Insurance -Life Insurance -Retirement -Uniforms -Worker's Compensation
3.	**Payroll Taxes** Cost of taxes paid by employer. Items include: -FICA -FUTA -SUTA
4.	**Total Salaries and Related Expenses.** For columns 1 through 6 and 20, add lines 1(a, b, c), 2 and 3.
5.	**Medicaid Supplies** **Supplies medically necessary to support treatment dictated in Mental Health treatment plan (not including medicines).**
6.	**Contract Labor** Cost incurred for all contracted treatment services.
7.	**Bloodborne Pathogen (OSHA)** Cost of meeting OSHA standards for bloodborne pathogens and infectious materials for Medicaid full-time equivalent employees. This includes supplies, protective equipment/ clothing, vaccinations, training materials, hazard signs/labels, waste disposal, and medical records retention.
8.	**Employee Criminal Records Check Fees** Cost of Medicaid full-time equivalent employee(s) Criminal Records Check fees. Background checks for Foster Parent providing Medicaid services.

9. **Other**
Cost not considered in the above accounts.

10. **TOTAL MEDICAID TREATMENT COSTS**
For columns 1 through 6 and 15, add lines 4 through 9.

11. **TOTAL MEDICAID RESIDENT DAYS PROVIDED**
For columns 1 through 6, indicate the number of Medicaid Resident Days provided for the respective level of care.

PROGRAM EXPENSES

SALARY EXPENSES (Do not include Social Work expense or Administrative Staff.):

Daily Supervision Cost

-Daily supervision in institutions includes routine day-to-day care, direct child care staff, and supervision of children, maintenance and food preparation workers and other institutional staff whose work assignments include functions that keep the program operating on a day to day basis.

-Activities related to supervising the care of the child and managing the child's individualized service plan include:

-Working with the child to develop the child's individualized Service Plan and working with the child on the status of the plan and plan goals;
-Giving information, instruction, guidance, and mentoring to the child.
-Monitoring and updating the child's Individualized Service Plan

12. **Salaries and Wages**
All personnel salaries and wages (Do not include Social Work)

13. **Employee Benefit Program**
Cost of benefits paid by employer. Items include:
-Dental Insurance
-Health Insurance
-Life Insurance
-Retirement
-Uniforms
-Worker's Compensation

14. **Payroll Taxes for Other Professional Staff**
Cost of taxes paid by employer. Items include:
- FICA
- FUTA
- SUTA

15. **Program Salaries and Related Expenses**
For columns 5 through 11 and 15, add lines 12 through 14.

SOCIAL SERVICES (SOCIAL WORK ONLY). Do not include Administrative Staff.

16. **Salaries and Wages for Social Workers Only**
Staff who perform Social Services activities including, *but not limited* to: Intake and Case Management, Foster Care Training, Parent recruitment and training, and Home Study preparation and supervision.

17. **Employee Benefit Program for Social Workers Only**
Cost of benefits paid by employer. Items include:
- Dental Insurance
- Health Insurance
- Life Insurance
- Retirement

18. **Payroll Taxes for Social Workers Only**
Cost of taxes paid by employer. Items include:
-FICA
-FUTA
-SUTA

19. **Total Social Workers Costs**
For columns 5 through 11 and 15, add lines 16 through 18.

HOUSEKEEPING/SHELTER COSTS:

Living space (indoor and outdoor) used by the children including rent or building use allowance: Furniture and upkeep of items related directly to shelter space used by the children: Fuel and utilities for space used by the children if the charges are not a part of the rent; Routine maintenance and upkeep of property and equipment used in the children's daily living activities.

20. **Cleaning Supplies**
Cost of cleaning and laundry supplies and materials. Items include: Brooms, Mops, Detergents, etc. -Non-Capitalized Equipment (vacuum cleaner, mop bucket, buffer, linen cart, scale, marking machine, etc.)

21. **Outside Laundry Supplies**
Cost of contracted Housekeeping and Laundry Supplies.

22. **Utilities**
Cost for all utilities. Items include:
-Electricity
-Gas (Natural gas, propane, butane – NOT gasoline)
-Fuel (Fuel oil used to heat and cool building – Not gasoline)
-Water (water and sewer services)

23. **Repair & Maintenance Building & Grounds**
Costs of all materials and labor to repair and maintain buildings and grounds.

24. **Repair & Maintenance Equipment**
Cost of all materials and labor to repair and maintain equipment. Items include:
-Office equipment
-Furniture and fixtures
-Plant machinery and equipment

25. **Sanitation & Pest Control**
Cost of sanitation (garbage) and pest control services.

26. **Rent-Facility**
Cost of renting or leasing facility where services are being provided and where residents live.

27. **Rent-Buildings/Land**
Includes rent of additional buildings for staff to meet resident requirements; temporary storage, land, etc.

28. **Linen & Bedding**
Cost of linen and bedding. Items include:
-Linens
-Bedding
-Sheets
-Mattresses
-Pillows and Cases
-Blankets
-Towels
-Washcloths

29. **Equipment**
Cost of equipment NOT affixed to building (not to include kitchen and dining room equipment)
Items include:
-Room Furniture and Fixtures
-Telephone Equipment
-Laundry Equipment

-Maintenance Equipment
-Lawn Mowers and Tractors
-Computer Equipment
-Software

30. **Miscellaneous**
Cost of other Housekeeping items not considered in the above accounts.
-Security system monthly charge for facility

31. **TOTAL HOUSEKEEPING / SHELTER COSTS**
For columns 5 through 11 and 15, total the expenses in the line items 20 through 30 described above.

DIETARY/FOOD COST:

-Actual food costs and kitchen and dining room operational costs including equipment and supplies associated with planning meals, ordering, preparing and serving food, cleanup work and the cost of planned meals away from the institution.

32. **Food**
Cost of food and nutritional supplements. Items include:
-Meats, Vegetables, Dairy Products, etc.

33. **Dietary Supplies/Equipment**
Cost of all dietary supplies. Items include:
-General Kitchen Supplies
-Plates, Cups, Forks, Knives, etc.
-Non-Capitalized Equipment (blender, coffee urn, food cart, etc.)

34. **Miscellaneous**
Cost of other Dietary items not considered in the above accounts.

35. **TOTAL DIETARY / FOOD COST.** For columns 5 through 16, these are the total expenses associated with items 32-34 described above.

PERSONAL NEED COSTS/CLOTHING:

36. **Clothing**
-Personal wardrobes (initial and replacement clothing).
-Expenses incurred in the upkeep of the children's clothing, including staff and supplies on the institution's grounds and for services provided off the institution's grounds, such as shoe repairs, mending, dry-cleaning, etc.

37. **Personal Hygiene Items**
-Personal hygiene items such as comb, brush, toothbrush, deodorant, soap, etc.

38. **Medical Supplies**
-Medical chest supplies, such as adhesives, dressings, gauze, gloves, syringes.

39. **Physician Fees & Hospitalization**
Costs of visits to the doctor and hospitalization costs (not to include prescription drugs)

40. **Non-Legend Drugs and Medical Services**
Costs of non-prescription drugs and x-rays and lab fees.

41. **Beauty and Barber Shop**
Cost of furnishing beauty and barber services and supplies to residents for basic hair care.

42. **Miscellaneous**
Costs of other Personal Needs items not considered in above accounts.

43. **TOTAL PERSONAL NEED COSTS / CLOTHING**
For columns 5 through 11 and 15, total the expenses in the line items 36 through 42 described above.

RECREATION COSTS:

44. **Recreational Supplies/Equipment/Games**
-Recreational program and services, including but are limited to reading materials, athletic equipment, games, etc.

45. **Recreational Allowance**
-A personal allowance for recreational activities.

46. **Youth Admission Fees**
-Admission fees to sporting or other recreational and cultural events including costs of snacks and treats purchased on outings (if not purchased from personal allowances).

47. **Youth Dues**
-Individual child's dues for youth clubs, scouts, community centers, (if not financed from a personal allowance).

48. **Miscellaneous**

Cost of other Recreation Activity items not considered in above accounts. Items include:
-Cable TV expense

49. **TOTAL RECREATIONAL COSTS**

For columns 5 through 11 and 15, total the expenses in the line items 44 through 48 described above.

EDUCATION COSTS:

50. **Educational Expenses**

-School supplies.

51. **Activity Fees**

-Fees paid for children to participate in activities such as field trips or other outings from the classroom.

52. **Class Dues**

-Dues paid for special projects, activities or events within the classroom.

53. **Travel Cost**

-Transportation to school or training programs if not provided or paid by other public funds or tax monies.- Specialized educational programs required by a child that are essential to his/her individualized program of care if no other source of funds is available or provided under any other state plan.

54. **Miscellaneous**

Costs of other Education Items not considered in above accounts.

55. **TOTAL EDUCATIONAL COSTS**

For columns 5 through 11 and 15, total the expenses in the line items 50 through 54 described above.

TRANSPORTATION:

56. **Travel Costs**

-Transportation intrinsic to the well-being of the child, including but not limited to, visits with relatives, prospective foster or adoptive parents, and other activities or events that are an integral part of the 24 hour program of care. Expenses for an attendant, when required, may be provided if it is not available for the child under the Title IV-B, Title XIX or Title XX program.

57.a **Miscellaneous**

Cost of other Transportation items not considered in above accounts.

57.b **TOTAL TRANSPORTATION COSTS**

For columns 5 through 11 and 15, total the expenses in the line items 56 and 57a described above.

58 **FOSTER CARE BOARD PAYMENTS TO FOSTER CARE PARENTS**

59 **ROOM AND BOARD EXPENSE**

The state standard room and board cost established for foster care maintenance reimbursement. Current state standard is a graduated rate based upon the age of the child. For columns 5 through 11 and 15, total the expenses on lines 31,35,43,49,55,57b and 58.

OTHER COSTS:

60. **Office Supplies**

Cost of office supplies and other administrative supplies.
Items include:

-General Office Supplies
-Printed Forms
-Letterhead and Envelopes
-Checks, Deposit Slips, and other Banking Forms
-Non-Capitalized Equipment (fax machine, calculator, etc.)

61. **Insurance-Vehicle - Cost is not Medicaid eligible.**

All insurance expense on vehicles used for home.

62. **Insurance-Fixed - Cost is not Medicaid eligible.**

Cost of insurance on Property ONLY (NOT liability, worker's compensation, life, or other non-property insurance).

63. **Insurance-General**

Cost of all other insurance not related to property or employees or vehicles.

64. **Automobile and Truck Maintenance - Cost is not Medicaid eligible.**

Cost of all maintenance and upkeep on vehicles owned by the home (other than cost applicable to Medically Related Patient Transportation). Items include:
-Registration Fees

-Gasoline
-Oil
-Tires
-Lubrication
-Vehicle Repairs

65. **Telephone**

Cost of telephone services for all communication services (including pagers, Internet service costs).

66. **Postage**

Cost of postage.

67. **Dues & Subscriptions - <u>Cost is not Medicaid eligible.</u>**

Cost of membership in professional societies, cost of trade journals and publications, and cost of subscriptions to newspapers and magazines for residents.

68. **Legal & Accounting**

Cost of acquiring contracted Legal and Accounting Services for home's operations.

69. **Interest-Automobile - <u>Cost is not Medicaid eligible.</u>**

All interest expense on vehicles used for home.

70. **Interest-Mortgage - <u>Cost is not Medicaid eligible</u>.**

Cost of all mortgage interest on:
-Land and Land improvements
-Buildings and Buildings improvements

71. **Interest-Fixed Assets - <u>Cost is not Medicaid eligible</u>**

Cost of interest on Fixed Assets. Items include:
-Equipment
-Automobile

72. **Interest-Operating**

Financing cost of operating capital for other than fixed assets (equipment, automobiles, etc.), mortgage (land, building), and automobiles. Items include:
-Interest on Operating loans
-Fees for General lines of Credit
-Interest on Credit Card Purchases
-Interest on other Revolving Credit Purchases

73. **Audit**-Cost of having an audit performed on the cost report by an Accountant or Certified Public Accountant (CPA).

74. **Rent-Automotive/Equipment - <u>Cost is not Medicaid eligible.</u>**
-All cost to rent or lease a vehicle used for home
-All cost to rent or lease equipment used for home

75. **Rent-Office**
Costs to rent office space to support operations of homes

76. **Real Estate Taxes**
Cost of all property taxes**.**

77. **Data Processing**
Cost of operating a data processing unit or contracted computer services. Item include:
-Contracted Data Processing Services
-Software Expense
-Data Processing Supplies

78. **Travel & Entertainment - <u>Cost is not Medicaid eligible.</u>**
Cost of travel and entertainment for business purposes.

79. **Licenses for Individuals - <u>Cost is not Medicaid eligible.</u>**
Cost of federal, state, and local licensing fees for individuals working in the facility.

80. **Licenses for Facility**
Cost of federal, state, and local licensing fees for the facility.

81. **Bloodborne Pathogen (OSHA) for Non-Medicaid FTE's**
Cost of meeting OSHA standards for bloodborne pathogens and Infectious materials for Non-Medicaid full-time equivalents. This includes supplies, protective equipment/ clothing, vaccinations, training materials, hazard signs/labels, waste disposal, and medical records retention.

82. **Employee Criminal Records Check Fees for Non-Medicaid FTE's**
Cost of employee Criminal Records Check fees for Non-Medicaid full-time equivalents. Background checks for Foster Parents providing Non-Medicaid services.

83. **Management Services**
Cost of contracted Management Services.

84. **Advertising - <u>Cost is not Medicaid eligible.</u>**
Cost of brochures, pamphlets, and all promotional and public relations expenses.

85. **Printing - <u>Cost is not Medicaid eligible.</u>**
Costs of printing brochures, pamphlet or other documents.

86. **Meeting/Seminars/Training - Cost is not Medicaid eligible.**
Costs of operations and maintenance personnel in attending meetings, seminars, and conferences. Items include:
- Tuition / Registration / Fees
- Training Materials

87. **Miscellaneous - Cost is not Medicaid eligible.**
Cost of other items not considered in above accounts.

88. **Salaries and Other Expenses**
Includes Administrative, Operational, and Maintenance Salaries

89. **TOTAL OTHER COSTS - Sum lines 60 through 88 for all columns.**

90. **TOTAL EXPENSES BEFORE DEPRECIATION**
For All columns, add lines 10, 15, 19, 59, and 89.

DEPRECIATION:

91. **Depreciation-Building, Improvement & Office - Cost is not Medicaid eligible.**
Cost of the building (s) and building improvements prorated over its expected life.

92. **Depreciation-Automotive - Cost is not Medicaid eligible**.
Cost of the purchase of an automobile or van used for home prorated over its expected life.

93. **Depreciation-Equipment - Cost is not Medicaid eligible**.
Cost of equipment NOT affixed to building prorated over its expected life.
Items include:
-Office Furniture and Fixtures
-Patient's Room Furniture and Fixtures
-Office Machines and Equipment
-Telephone Equipment
-Security equipment

94. **TOTAL DEPRECIATION.**
For columns 5 through 15, add lines 91 through 94.

95. **TOTAL RATE SETTING EXPENSES.**
For ALL columns, sum lines 90 and line 94.

NON-ALLOWABLE EXPENSES:

96. **Child Development**
-Provision of day care

97. **Other Child and Family Services**
-The provision of non-residential social services directed toward families and children, i.e., counseling an intake family.

98. **Higher Education**
-Educational support of children beyond high school.

99. **Bad Debts**
-Uncollectible debt.

100. **Multi-Purpose Group Home**
-Office of Juvenile Justice facilities operated for juveniles for the purposes of treatment and secure detention.

101. **Miscellaneous and Non-allowable cost**
-Other items not considered in above accounts, i.e., legal expenses related to staff entertainment, costs of research and development except when resulting in benefit to home

102. **In Kind Donations/ Contributions**
-In kind donations and contribution, if included as an expense item
in the Statement of Functional Expense or the Expense portion of the Income and Expense Statement.

103. **Penalties - any penalty form any source.**

104. **Extra Ordinary Items –** to allow inclusion of allowable expense designated as an Extra Ordinary Item by the Auditor and not included in the Statement of Functional expense.

105. **TOTAL NON-ALLOWABLE EXPENSES.**
Sum of lines 96 through 104.

106. **TOTAL TO MATCH AUDIT/FINANCIAL STATEMENTS**
(the total of all expenditures for all columns, added are line 95 plus line 105). Please verify that your Schedule C ties to your Audit/Financial Statements. If DMA Rate Setting can not **verify these numbers for each program**, please provide a supplemental schedule and, if applicable, have your Independent Auditor attest.

107. **TOTAL RESIDENT DAYS PROVIDED.** Entering the **treatment days** into Schedule C-1 Line 11, will carry forward to consolidate on Schedule C in columns 1 through 6 on line 11 and will carry forward to this line. For columns 7 through 11, please enter directly into line 107 in the appropriate column, residential days for **non treatment**. If you are preparing the cost report on paper, enter the resident days provide for each service. These resident days should balance with the Schedule A, resident days reported.

INSTRUCTIONS FOR EXPENSE SCHEDULE C-1

Use the Instructions for completing Schedule C to complete Schedule C-1 with the following notes:

Position Count/FTE's per category: On the first line, across the top of the form, for each category, indicate the number of full time equivalent personnel which are associated with and represent the costs of the category.

Full-time equivalent (FTE). If a person works full time for one year with an agency, they are consider 1 FTE. If they only worked half time for a full year, they would be 0.5 FTEs. FTEs can be calculated based on the number of hours worked divided by 2080 hours (which is a full time person for a full year)

Please reference the 2004-2005 provider service definitions for Residential Level I, II, III, IV, and PRTF for the specifics of the treatment costs to be included in the respective column. Medicaid can cover treatment cost as long as there is medical necessity and there is a treatment plan for the child.

Do not include Room & Board costs in Columns 1 through 10 corresponding to lines 1 through 9. These costs should be included on SCHEDULE C under the respective Room and Board Columns 7 through 10.

- No expenses should be allocated to columns where the line items that have shaded boxes on them.

- Cost Report Line #'s 1 through 11 are exactly the same as in the instructions for Schedule C.

- Columns 1 through 7 on Schedule C-1 are summarized and carried to columns 1 through 4 on schedule C.

- Columns 8 and 9 on Schedule C-1 are carried to Schedule C in columns 5 and 6. There is no difference between Schedule C and Schedule C-1, in the way these columns are handled.

- Total lines are the same through out both Schedule C-1 and Schedule C.

INSTRUCTIONS FOR RELATED PARTY TRANSACTIONS SCHEDULE D

For each type of related party cost/expense, please complete the following fields:

(1) Description of the expense/cost line item
(2) Identification of the line item number from the cost report
(3) Enter the applicable Program/Cost Center/Column from the cost report
(4) Name of the related party (organization and/or individual)
(5) Description of the relationship between the related party and the home. Examples are:
- Parent company
- Subsidiary
- Subsidiary of a common parent company
- Principal owner
- Immediate family of principal owners
- Management
- Immediate family of management
- Affiliate (a party that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the home)
- Different divisions within the same company

(3) Total amount of the related party transaction/expense
(4) Total number of paid hours, if applicable, that corresponds to the expense (salaries and wages, casual labor and contract services) being reported

Compensation to Owners and Owner Related Individuals:

Allowance of Compensation and Recordkeeping Requirements:

Owners of provider organizations often render services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the necessary services rendered be an allowable cost. To do otherwise would disadvantage such owners in comparison with corporate providers or providers employing non-owner persons to perform the same services.

Distribution of profits is a form of compensation paid to a proprietor. However, this form of compensation is **not an allowable cost** of the facility because it is not contingent on performance of necessary services. Where a proprietor renders necessary services for the institution, the institution is, in effect, employing his services and a reasonable compensation for these services is an allowable cost. The salaries of owners and owner-related employees are subject to the requirements of reasonableness. Reasonableness of compensation will be determined by reference to or in comparison with compensation paid for comparable services and responsibilities in comparable institution or it may be determined by other appropriate means. Where the services are rendered on less that a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis.

Compensation for services of owners and owner-related employees shall be an allowable cost provided these services are adequately documented to be necessary, and such employees are adequately documented to be qualified to provide these services. Adequate documentation shall include but not be limited to:

(1) Date and time of services contemporaneous recordkeeping
(2) Position description
(3) Individual's educational qualifications, professional title, and work experience
(4) Type and extent of ownership interest
(5) Relationship to and name of owner (if an owner-related individual)

Definitions:

A. **"Related to the facility"** means that the facility, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization and/or individual furnishing the services, facilities, or supplies.

B. **"Common ownership"** exists when an individual or individuals possess significant ownership or equity in the home and the institution or organization serving the home.

C. **"Control"** exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. The term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise.

D. **"Necessary services"** are those services needed for the efficient operation and sound management of the facility such that had the owners or owner-related individual not rendered the services, the facility would have had to employ another person to perform the services.

E. **"Ownership interest"** means the entitlement to a legal or equitable interest in any property of the facility whether such interest is in the form of capital, stock, or profits of the facility.

F. **"Owner" –** shall be considered any individual with a 5% or more ownership interest in the facility.

G. **"Owner-Related Individual" –** An owner-related individual shall be considered an individual who is a member of an owner's immediate family which includes spouse, natural or adoptive parent, natural or adopted child, stepparent, stepchild, sibling or stepsibling, in-laws, grandparents and grandchildren.

H. **"Compensation"** means the total benefits received by the owner for the services he renders to the institution. Such compensation shall include:

(1) Salary amounts paid for managerial, administration, professional, and other services
(2) Amounts paid by the institution for the personal benefits of the proprietor
(3) The cost of assets and services which the proprietor receives from the institution
(4) Deferred compensation
(5) compensation reported for tax purposes

In determining whether a facility is related to a supplying organization and/or individual, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other.

The existence of an immediate family relationship will create an irrefutable presumption of relatedness through control or attribution of ownership or equity interests. The following persons are considered immediate family for program purposes:

(1) Husband and wife
(2) Natural parent, child and sibling
(3) Adopted child and adoptive parent
(4) Step-parent, step-child, step-sister, and step-brother
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law
(6) Grandparent and grandchild

Some examples of common types of transactions between related parties are:

(a) Sales
(b) Purchases
(c) Transfers of realty and personal property
(d) Services received or furnished (i.e. accounting, management, engineering, and legal services)
(e) Use of property and equipment by lease or otherwise
(f) Borrowing and lending
(g) Guarantees
(h) Maintenance of bank balances as compensating balances for the benefit of another
(i) Inter-company billings based on allocations of common costs
(j) Filings of consolidated tax returns

MENTAL HEALTH RESIDENTIAL TREATMENT COST REPORT EXEMPTION FORM

Due Date: JANUARY 31, 2006

Applicant Completes:

- (Tax ID) _____
- (Agency Name) _____
- (Agency Address) _____
- (Agency Phone #) _____ Agency FAX #) _____

We are requesting exemption from the 2006 Mental Health Residential Treatment Cost Report due to: [check appropriate reason/s]

_____ submitted the ***Residential Treatment and Foster Care Cost Report - 2005-2006*** to the DHHS, Office of the Controller.

_____ was not in business for ***at least 6 months.***

_____ does not meet the Medicaid minimum dollar threshold of ***$230,000*** per Agency Tax ID# in revenue generated from providing Medicaid Residential Treatment Services. This threshold has been established based on cumulative revenue by Tax ID. For multi-facility agencies, combine the revenue for all individual facilities to determine if you meet the minimum dollar threshold.

(Medicaid Provider #) _____	(Medicaid Provider #) _____
(Medicaid Provider #) _____	(Medicaid Provider #) _____
(Medicaid Provider #) _____	(Medicaid Provider #) _____
(Medicaid Provider #) _____	(Medicaid Provider #) _____
(Medicaid Provider #) _____	(Medicaid Provider #) _____

Please attach additional sheet if more Medicaid Provider #s are needed.

- (Date):_____
- (Signature of the Provider Agency):_____
- (Printed name of person signing above):_____